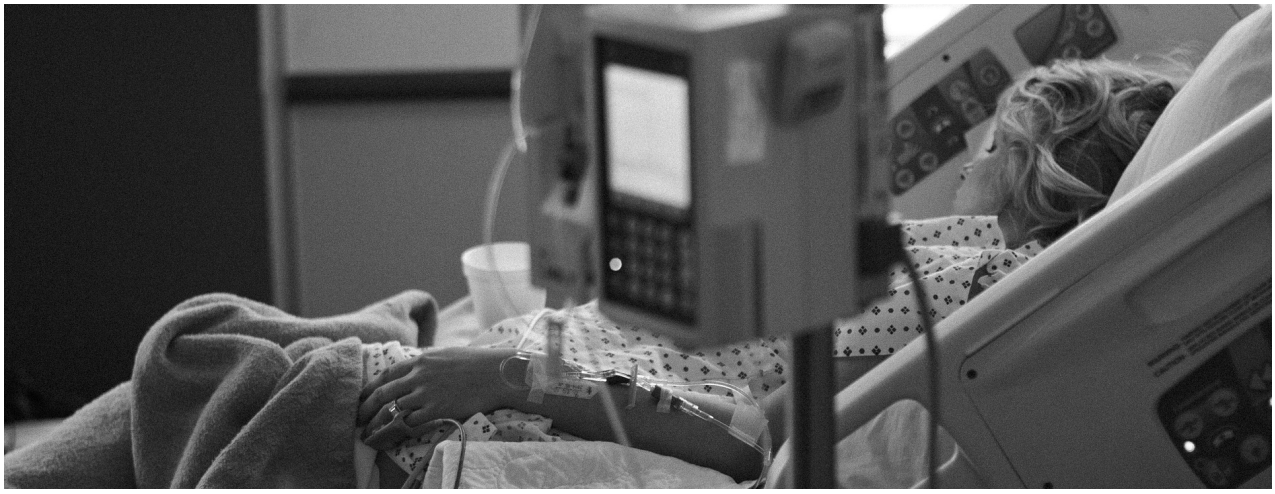
University of Nevada Cooperative Extension

FS-18-02

PEER REVIEWED

The Medical Cost of Domestic Violence

Authors:
Crystal Powell, Site Coordinator, Churchill County | Pamela Powell, Extension Educator, Churchill County | Jill Baker-Tingey, Extension Educator, Elko County



What is Domestic Violence?

Domestic violence is defined as a pattern of abusive behavior in a relationship, where one intimate partner uses violence to gain and/or maintain power and control over another (U.S. Department of Justice, Office of Justice Programs, 2011). It is well-known that intimate partners, children, elders and extended family members, friends, and

even pets can be victims of abuse. What is less-known is the enormous financial cost domestic violence places on society, in terms of housing, child care, employment and criminal justice services. Medical services are one of the largest components of domestic violence's financial burden.

Annual Cost of Domestic Violence

In 2003, the Centers for Disease Control and Prevention (CDC) published a study analyzing 1995 domestic violence-related medical data. In total, domestic violence costs the United States $5.8 billion. The largest share, $4.1 billion, was spent on medical and mental health care costs. However, these costs are considered underestimates, as the 1995 study focused specifically on women ages 18 and older, and did not account for children and men. In addition, only women who were physically injured during an incident were asked about their medical costs. All surveyed women, whether physically injured or not, were asked about their mental health care (Centers for Disease Control and Prevention, 2003). The CDC also did not account for inflation rates on services in the eight years between 1995, when the data was collected, and 2003, when the study was published. (To date, the CDC referenced study provides the most current information, and is often cited in recent literature.)

Direct Versus Indirect Costs of Domestic Violence

The $5.8 billion price tag for domestic violence, divided into medical and mental health services, was also divided into actual health care costs and loss of productivity in a victim's work and home life.

Direct costs are "the actual dollar expenditures" of domestic violence-related medical and mental health services, including ambulance transports, hospitalizations and physical therapy.

Indirect costs "represent the value of lost productivity from both paid work and household chores for injured victims" (Centers for Disease Control and Prevention, 2003). Indirect costs include the number of days lost at work and household chores due to the victim's physical injury and mental distress. They also include the loss of projected future income of women murdered in domestically violent relationships,

accounting for average life expectancies based on age group, income patterns for respective fields, and household earnings for women both in and out of the workforce. This fact sheet will only focus on the direct costs.

Average Cost of Victimization (By Type)

The CDC (2003) surveyed female domestic violence victims based on three types of domestic abuse, referred to as “victimizations:”

- Rape
- Physical assault
- Stalking

The CDC further reported that the cost of each victimization included the average cost of one medical and one mental health service as follows:

- $838 per rape
- $816 per physical assault
- $294 per stalking

However, these costs reflect a victim seeking services only once. They do not reflect follow-up care. For women who sought follow-up treatment, costs included therapy and counseling for mental health issues, and ambulance transport and paramedic care for medical services.

The average costs per incident for women who received follow-up treatment were as follows:

- 12.4 mental health visits and 1.3 - 13.4 medical visits depending on service (ER versus physical therapy) per rape
- 12.9 mental health visits and 1.1 - 21.1 medical visits depending on service (ER versus physical therapy) per physical assault
- 9.6 mental health visits per stalking. No medical costs were recorded for stalking.

According to these rates, women who sought additional treatment spend an average of:

- $3,062 per rape
- $3,682 per physical assault

- $690 per stalking

As most women were victimized at a rate of one to four times a year (rates vary based on type of abuse experienced), female victims annually spent an estimated:

- $838 - $1,340.80 a year on rape (1.6 victimizations a year)
- $816 - $2,774.40 a year on physical assault (3.4 victimizations a year)
- $294 on stalking (one victimization a year)

Nevada Statistics

In the National Domestic Violence Hotline's 2015 Nevada State Report, 71 percent of callers sought help for physical abuse, while 8 percent sought help for sexual abuse (2015). When applying the CDC's national statistics to the hotline's 1,791 Nevada callers*, approximately 1,272 experienced physical abuse, while 143 experienced sexual abuse. Based upon these reports, it is likely Nevadans may have collectively spent:

- $119,834 on rape
- $1,037,952 on physical abuse

*This does not account for Nevada victims who sought ongoing treatment for their abuse, nor does it account for the inflation rates between the CDC's 1995 and the National Domestic Violence Hotline's 2015 data. Stalking statistics were unavailable.

Health Care Prevention

Since 24 percent to 54 percent of women who use emergency room services use them as a direct result of domestic violence, health care professionals are not only in a unique position to identify and help victims, but also to reduce associated health care costs. As many as 45 percent of the cases could be detected if healthcare professionals were trained to screen patients for domestic violence (Centers for Disease Control and Prevention, 2003 and Hamberger, L., Rhodes, K., & Brown, J., 2015). Screening is not limited to current assaults. Domestic violence survivors use medicals services for abuse up to 16 years after their relationship ends (Hamberger, L., Rhodes, K., & Brown, J., 2015). Indeed, most screenings relying on the presence of physical injury are

not sufficient. Chronic conditions, such as depression, pain, sexually transmitted infections and sleep disturbances, are also warning signs, yet no one sign is an accurate “predictor” of domestic violence (Violence Against Women: What health workers can do, 1997).

Despite the complex nature of screening, interviews as short as two minutes have been proven effective in detecting abuse in pregnant women (Futures Without Violence, n.d.). The fact that chronic illness and pain generates the greatest financial burden on the health care system highlights an incentive to train health care providers to recognize and report domestic violence (Dolezal, T. D., & Callahan, E. M., 2009).

Example Screening Protocol

One example of a training to screen victims is the *Domestic Violence and the Role of the Healthcare Provider* seminar, created in June 2012 by the Robert Wood Johnson University Hospital Community Health Promotion Program; the New Brunswick Domestic Violence Awareness Coalition; and Anna Trautwein, RNC, of Saint Peter’s University Hospital (Hewins, E., DiBella, B., & Mawla, J., 2013). The three-hour training educated health care professionals in screening techniques, such as how domestic violence warning signs present in patients:

- The patient’s partner is overbearing in health care appointments, accompanying her in every setting and deciding what treatment options she will use.
- The patient sporadically attends scheduled visits, missing appointments.
- The patient’s medical complaints have no obvious cause.
- The patient is aloof, quiet and/or awkward.

The training also taught providers how to develop compassionate relationships with patients, recommending they screen patients during the tension-building phase of the violence (before an assault), when the victims are less likely to make excuses for the abuser and more likely to open up about the abuse (Hewins, E., DiBella, B., & Mawla, J., 2013).

Information on helping patients formulate a safety plan and connecting them to local domestic violence resources is also covered. An example of the training’s screening questions are provided in Appendix A.

In an online survey taken months after the trainings, 77.7 percent of the student professionals said the class helped them understand the important role health care providers have in identifying and helping victims. Moreover, they said they felt confident in doing so (Hewins, E., DiBella, B., & Mawla, J., 2013).

Conclusion

Health care surveillance methods are one way to tackle and help eliminate the medical injuries and costs of domestic violence. Domestic violence is the single greatest risk factor to a woman's health, greater than cigarette smoking or obesity (Hewins, E., DiBella, B., & Mawla, J., 2013). In "The Medical Providers' Guide to Managing the Care of Domestic Violence Patients within a Cultural Context," a manual developed by New York City's Mayor's Office to Combat Domestic Violence, 95 percent of patients who were screened and provided services had not sought help from other organizations before the screening (Weber, T., & Levin, L. K., 2004). Other research suggests current domestic violence health care costs could be reduced by 20 percent if health care providers were trained to screen victims (Futures Without Violence, n.d.). Potentially, health care provider screenings could identify a majority of victims, significantly reducing the costs and the occurrence of domestic violence.

Domestic violence not only injures its victims, but also injures the community and economy in which victims live. Therefore, there is a collective, community incentive to tackle the issue. Only by further educating health care providers and agencies can we support the healing process.

References and Suggested Reading

Centers for Disease Control and Prevention (CDC). Costs of intimate partner violence against women in the United States (https://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf). Atlanta (GA): CDC, National Center for Injury Prevention and Control; 2003.

Dolezal, T. D., & Callahan, E. M. (2009). Hidden Costs in Health Care: The Economic Impact of Violence and Abuse (http://www.ccasa.org/wp-content/uploads/2014/01/economic-cost-of-vaw.pdf). In Academy of Violence and Abuse. Retrieved October 24, 2017.

Futures Without Violence. (n.d.). The Facts on Health Care and Domestic Violence (https://police.ucsf.edu/system/files/domesticviolencehealthcare.pdf). In Family Violence Prevention Fund. Retrieved October 24, 2017.

Hamberger, L., Rhodes, K., & Brown, J. (2015, January 1). Screening and Intervention for Intimate Partner Violence in Healthcare Settings: Creating Sustainable System-Level Programs (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302953/). Journal of Women's Health, 24(1), 86-91. Retrieved October 24, 2017.

Appendix A

ROUTINE SCREENING QUESTIONS		
DIRECT	INDIRECT	FRAMING
Use with heightened index of suspicion, and the presence of one or more increased risk indicators. Include regardless of how the issue of DV is initially raised.	In some clinical settings it may be more appropriate to begin inquiry with an indirect question before proceeding to more direct questions.	Effective to initiate conversation when it seems/ feels awkward to suddenly introduce the subject of abuse/violence, particularly when there are no obvious indications.
SAMPLE QUESTIONS		
DIRECT	INDIRECT	FRAMING
Do you (or did you ever) feel controlled or isolated by your partner?	You seemed concerned about your partner. Can you tell me more about that? Does he ever behave in ways that frighten you?	We now know that domestic violence is a very common problem. More than 30% of women in this country will report being abused by their partners. Has this ever happened to you?
Has your partner ever hit you or physically hurt you? Has he ever threatened you, someone close to you or made you feel afraid?	How are things going in your marriage? All couples argue, sometimes. Are you having fights? Do your fights ever become physical?	I don't know if this is a problem for you, but some of the women I (we) see are dealing with abuse in their relationships. Some are too afraid or uncomfortable to bring it up themselves, so I (we) have started to ask about it routinely."

From Page 18 of "Domestic Violence and the Role of the Healthcare Provider: The Importance of Teaching Assessment and Intervention Strategies (http://www.nj.gov/dcf/women/archive/WhitePaper_DomesticViolence.pdf)" (Hewins, E., DiBella, B., & Mawla, J., 2013).

University of Nevada Cooperative Extension
Mail Stop 404
1664 North Virginia Street
Reno, Nevada 89557

Phone 775-784-7070 (tel:7757847070)
Fax 775-784-4227
Max C. Fleischmann Agriculture, Room 201